Emergency Housing and Assistance Program
(EHAP) Funding Round XI
(EHAP-XI)

Statewide
Application Package

September 12, 2003

State of California
Department of Housing and
Community Development

EHAP-XI STATE APPLICATION CHECKLIST AND CERTIFICATION

General Instructions: Read the Regulations and the Budget Act of 2003 carefully. Prepare a separate Operating Facility application for each site (or project, if on scattered sites; see Regulations for definition of "site"). Use this index/checklist to ensure you organize and include all necessary information. Please type or print neatly.

Submit two complete sets of the application, one with original signatures and one copy. Mark each set original or copy.

1. Please submit the original in a white 3-ring binder. Display your agency name and the County in which you are applying for funds on the spine. Submit the copy bound together with a rubberband or clip, a binder is not necessary.

2. Use numbered tabs and divide the binder into 3 sections: 1, 2 and 3. It is not necessary to insert dividers into the copy of the application but follow the same order as the original application.

3. In each section, set up dividers with lettered tabs to correspond to the index below. Place requested documents behind their corresponding tabs.

4. For items that are not applicable to your application, place sheets saying "Not Applicable" behind the tabs corresponding to those items.

5. If your organization is applying for an Emergency Shelter grant and a Transitional Housing grant for the same site, seperate applications must be submitted.

APPLICANT NAME:_____

COUNTY(IES):_____

NUMBER OF ORIGINAL EHAP-XI APPLICATIONS SUBMITTED: _____

AMOUNT OF THIS GRANT REQUEST: $ _____

TYPE OF GRANT: (check one) _____ Operating Facility _____ Operating Facility with capital development-type activities of $20,000 or less

TYPE OF SHELTER: (check one only)
EMERGENCY SHELTER _____
TRANSITIONAL HOUSING _____

BRIEF SUMMARY DESCRIPTION of proposed use of this EHAP grant: (25 words or less)

All applicants must complete and submit the Checklist and Certification, Section I and II. Applicants applying for any amount of capital development-type activities (Acquisition, New Construction, Rehabilitation, Conversion, or Equipment) must also submit Section III. (Applications missing mandatory items will be considered ineligible and will not be rated and ranked.)

[ ] STATE APPLICATION CHECKLIST AND CERTIFICATION
(Page 1 and 2)

SECTION I: APPLICATION FORMS AND NARRATIVE (ALL APPLICANTS)

[ ] A. General Applicant Information
[ ] B. Applicant Eligibility
[ ] C. Narrative Questions and Project Staffing form
[ ] D. Income and Expense Statement
[ ] E. Type and Total Amount of EHAP Grant Request
[ ] F. Summary Budget and Fund Request
[ ] G. Detail of Operating Facility Grant
[ ] H. Payee Data Record (form provided in application)
--Not required for Cities or Counties

SECTION II: ADDITIONAL ATTACHMENTS (ALL APPLICANTS)

[ ] A. Authorizing resolution of governing board using Sample Resolution language and format
[ ] B. Organization chart
[ ] C. Policies and conditions of stay (e.g., intake procedures, house rules)
[ ] D. Copy of IRS Form 501(c)(3), or local government authorizing resolution
[ ] E. Board roster
[ ] F. Copy of most recent annual fiscal report
[ ] G. Copy of Articles of Incorporation and any amendments

SECTION III: ADDITIONAL GRANT PROPOSAL INFORMATION FOR OPERATING FACILITIES GRANT APPLICANTS WITH CAPITAL DEVELOPMENT-TYPE ACTIVITIES (i.e. Acquisition, New Construction, Rehabilitation, Conversion, or Equipment)

[ ] A. Site Description
[ ] B. Capital Development Project Activities Schedule
[ ] C. Detailed Cost Estimates

CERTIFICATION OF APPLICATION INFORMATION

I am authorized to apply on behalf of _____ and attest that all information contained in this application is accurate and complete to the best of my knowledge. All information contained in this application is acknowledged to be public information. I authorize the Department of Housing and Community Development to contact any or all of the parties listed in this proposal.

_____
Authorized Signature for Applicant (authorized by resolution)

_____
Printed Name and Title

_____
Date

Please follow these step-by-step instructions for completing the Application Summary Form on the following two pages. It is important for reviewing purposes that the "Information" section be completed correctly.

Applicant Name: Provide the name of the organization that will be administering the funds. This must be the same as stated on the Resolution and the Articles of Incorporation and any amendments (submitted as in Section II, Attachment G). If it is different from one or both of these documents, an explanation must be provided on a separate sheet of paper and attached immediately behind the first page of the Application Summary Form. **Do not include DBAs.**

County: Provide the name of the county where the funds are to be allocated. This may be different from the county where the shelter/program is actually located/operated.

Type of Applicant: Indicate whether the applicant is a Nonprofit or Government Agency. Community Action Agencies will be considered a nonprofit unless the resolution is from the Board of Supervisors.

Total Grant Amount: Provide the total grant amount you are requesting in this application.

City: Provide the name of the city(ies) where the shelter/program is located/operated. This is not where the administrative office is located unless it is located onsite at the shelter/program.

County: Provide the name of the county where the shelter/program is located/operated. This may or may not be the same as the "County" provided above. This is not where the administrative office is located unless it is located onsite at the shelter/program.

Authorized Signatory Representative: Provide the name and title of the person that is authorized to sign the Application and the Standard Agreement as stated in the Resolution.

Street Address or P.O. Box City and Zip Code: Provide the address for the administrative office.

Telephone Number: Provide the phone number for the administrative office.

Fax Number: Provide the fax number for the administrative office.

Contact Person: Provide the name and title of the person to be contacted regarding the grant.

Telephone Number: Provide the phone number for the person to be contacted regarding the grant. Include an extension number if available.

Fax Number: Provide the fax number for the person to be contacted regarding the grant.

Email Address: Provide the email address for the person to be contacted regarding the grant.

Amounts Requested for Each Major Funding Category: Indicate the dollar amounts for each major funding category that you are applying for. Administration cannot exceed 5% of the total grant amount. The total must equal the total grant amount indicated above.

Target Population: Check the box next to each of the primary target populations that will be served by this project. If the group isn't listed, please check "Other" and briefly indicate who the population is on the line provided.

Project/Shelter Information: Provide information for actual shelter location(s) if they are different from the application name and mailing address.

Project/Shelter Name-Address-City-County: Provide the name, address, city, and county for all of the sites. If this is a multi-organization application, also provide the organization name for each site. If the address is confidential, so state, indicate the reason, and provide the city, county, and zip code of the site.

Target Population(s): Indicate the numerical code for each of the primary target populations served at this site. The code is the number next to the code checked above.

Requested Amount: Indicate the portion of the grant amount requested for this site.

Average Number Served Daily: Please utilize the following formula to determine this count.

1. Take your daily count of persons served and project it over the next twelve months (duplicate counts of the same persons served on different days is acceptable).
2. Divide this number by 12.
3. Divide the product by 30.
4. Round this product to the nearest whole number.

Sample: 24,000 persons to be served within the next twelve (12) months / 12 = 2000
2000 / 30 = 66.66 (rounded to 67)

Type of Assistance Requested: Put an "X" in the box next to all that apply. You much choose either "Emergency Shelter" or "Transitional Housing." In addition, choose "Voucher" and/or "Residential Rental Assistance" if these apply. Do not enter dollar amounts.

Legislative Representative: Indicate the District Number, name, and mailing address for the Assembly and Senate Member for the project'(s) location. If unknown, consult the State Government Offices section of the white pages of your Phone Book, under Assembly and Senate or call the Chief Clerk at the Capitol at (916) 445-3614.

Operations Detail: Indicate the dollar amount requested for each Operations Detail. These should add up to the "Operations" amount from the previous page under "Amounts Requested For Each Major Funding Category." If the item isn't listed, please check "Other" and briefly indicate what the item is on the line provided. Rent will now be a Major Funding Category. In the past Rent was included within "operations" but it will now be tracked separately.

GENERAL APPLICANT INFORMATION

Emergency Housing and Assistance Program (EHAP)		
Application Summary Form		
Type of Information	**Information**	**Instructions**
Applicant Name		**Must be same as stated on the Resolution**. As incorporated (from 501(c)(3), or Articles of Incorporation); if different from one or both of these, explain why in a separate sheet of paper, attached immediately behind this page. **(DO NOT INCLUDE DBAs)**.
County		County where funds are allocated.
Type of Applicant	☐ Nonprofit **or** ☐ Government	Community Action Agencies will be considered a nonprofit unless the resolution is from the Board of Supervisors.
Last 4 digits of grant #		**For State Use Only. Leave Blank.**
Total Grant Amount		Input the grant amount you are requesting.
City		Where the **shelter/program** is **located/operated**. This is **NOT** where the **administrative office** is located **unless** it is located onsite at the shelter/program applied for.
County		
Authorized Signatory Representative Name AND Title	☐Mr. ☐Ms. ☐Other_____	As stated on the Resolution. This is the title or position of the person that is authorized to sign the Application and the Standard Agreement.
Street Address or P.O. Box City and Zip Code		Information for the administrative office.
Telephone Number		
Fax Number		
Contact Person Name AND Title	☐Mr. ☐Ms. ☐Other_____	This is the person we will call regarding your grant. Please make sure the correct person is listed. Include a telephone extension number if available.
Telephone Number		
Fax Number		
Email Address		
Title and Last Name		**For State Use Only. Leave Blank.**
Amounts Requested For Each Major Funding Category:		
Acquisition	$	Input the dollar amount for each Major Funding Category that you are applying for.
New Construction	$	
Rehabilitation	$	
Conversion	$	
Equipment	$	
Operations	$	
Mortgage Payments	$	
Lease	$	
Rent	$	
Residential Rental Assistance	$	
Vouchers	$	
Administration	$	Maximum 5% of the Total Grant Amount.
TOTAL	$	Must equal "Total Grant Amount" from above.

Target Population: check the primary target population(s) that will be served by this project

1. ☐ Physically Disabled	8. ☐ Seniors
2. ☐ Persons with AIDS	9. ☐ Mentally Ill
3. ☐ Youths	10. ☐ Veterans
4. ☐ Single Adults	11. ☐ Victims of Domestic Violence
5. ☐ Single Men	12. ☐ Substance Abusers
6. ☐ Single Women	13. ☐ Dually-Diagnosed
7. ☐ Families	14. ☐ Other: _____

Project/Shelter Information: Actual shelter location(s) If multi-organization application, list all site names, organization name, address, city, and county information. If address is confidential, so state and indicate reason and give **city, county, and zip code** of the project. Please insert code number(s) of target population(s).

Project/Shelter Name – Address – City – County -- Zipcode	Target Population(s)	Requested Amount:	Average Number Served Daily:
1.		$	
2.		$	
3.		$	
4.		$	

Type of Assistance Requested:

Emergency Shelter		Put an "X" in the information box of all that apply. You must choose either Emergency Shelter **OR** Transitional Housing, **not both**. DO NOT ENTER DOLLAR AMOUNTS.
Voucher		
Residential Rental Assistance		
Transitional Housing		

Legislative Representative:

Assembly District No.		Senate District No.	
Assembly Member Name and Address		Senate Member Name and Address	

Operations Detail:

Staff	$	Input the dollar amounts requested for each line item within Operations. Administration is **not** included within Operations; input Administration seperately as a Major Funding category on page 5. Please explain "Other"
Counseling	$	
Utilities	$	
Office Supplies	$	
Routine Maintenance	$	
Taxes and Insurance	$	
Other: _____	$	
TOTAL OPERATIONS	$	Equals Operations line on page 5

B. APPLICANT ELIGIBILITY.

Answer each of the following questions to determine your eligibility pursuant to section 7959 of the Regulations. Please make sure your answers are accurate, as we will use this information to determine eligibility.

1. Authority: _____ Public Agency _____ Nonprofit Corporation (501(c)(3))

2. When did your organization begin providing client housing (month/year)? _____ /____

   Has the client housing been provided continuously for the last 12 months? _____ Yes _____ No

   If housing is only provided seasonally, give dates of most recent period when housing was provided:

   _____ /_____ to _____ /_____

3. Does the shelter/facility for which EHAP funding will be used contain any of the conditions of a substandard building listed in Health and Safety Code section 17920.3? _____ Yes _____ No

   If yes, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is Yes.

4. Is a client required to participate in any religious or philosophical service, ritual, meeting or rite as a condition of receiving shelter? _____ Yes _____ No

   If yes, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is Yes.

5. **Before answering Question #5 below, please read the Department's policy document entitled "Serving Selected Populations With EHAP Funding" located in Appendix "A" of this application.**

   Failure to explain your answer where a question asks you to "please explain" may result in rejection of your application for incompleteness.

   5A. **Emergency Shelter Applicants Only** (Transitional Housing Applicants skip to Page 9, Question 5B.)

   1) Does your emergency shelter target a particular subpopulation of homeless persons at the emergency shelter for which EHAP funds are being requested?

      ____ No **If "no,"** skip to Question 6.

      ____ Yes **If "yes,"** answer Question 2 below:

   2) Does your emergency shelter target services exclusively to either men or women?

      ___ Yes **If "yes,"** describe the target subpopulation in the following blank_____**and** skip to Question 6.
      (target subpopulation)

      ___ No **If "no,"** answer Question 3 below:

   3) Does your emergency shelter target services exclusively to persons 24 years of age or younger?

_____ Yes **If "yes,"** describe the target population in the following blank_____, and skip to Question 6.
(target population)

____No **If "no,"** answer Question 4 below.

4) If you had an available bed at your emergency shelter, and a person who is not a member of that facility's target population requested a bed, would you deny that available bed to that person?

___ Yes **If "yes,"** answer Question 5 below.

___ No **If "no,"** skip to Question 6.

5) In circumstances where any client is denied emergency shelter when there is a vacancy, would you ensure that there is adequate alternate accommodation – including arranging for a bed or providing a voucher for a bed at an alternative facility and reasonable transportation to that facility?

____Yes **If "yes,"** please answer a) and b) below:

____No **If "no" to Question 5 above, you are not eligible for EHAP funds. Ineligible applicants may contact EHAP staff for technical assistance.**

a) Identify the facilities and organizations you partner with to provide alternate shelter accomodations:

Facility Name/Address	Facility operated by (organization name)	Population Served by the Facility

AND;

b) List the type(s) of transportation to an alternate facility you will provide.

Type of transportation	Name of Alternate Facility

c) Are the forms of transportation set forth above reasonably accessible and available to persons turned away from your facility? _____ yes _____ no

Considering individual needs and the time and distance involved in traveling to the alternate facilities, briefly explain your organization's implementation plan.

_____
_____
_____

5B. **Transitional Housing Applicants Only:**

1) Does your transitional housing facility target a particular subpopulation of homeless persons for which EHAP funds are being requested?

____ No **If "no,"** skip to Question 6.

____ Yes **If "yes,"** answer Question 2 below:

2) Does your transitional housing facility target services exclusively to either men or women?

___ Yes **If "yes,"** describe the target subpopulation in the following blank_____**and** skip to Question 6.
(target subpopulation)

___ No **If "no,"** answer Question 3 below:

3) Does your transitional housing facility target services exclusively to persons 24 years of age or younger?

_____ Yes **If "yes,"** describe the target population in the following blank_____, **and** skip to Question 6.
(target population)

____No **If "no,"** answer Question 4 below.

4) Is there a State or Federal law or regulation that requires your transitional housing facility to exclusively serve a select homeless subpopulation?

___Yes **If "yes,"** in the space below list the applicable State or Federal law or regulation, and the agency that requires it. **Then** skip to Question 6.

State/Federal law or regulation citation (include name of code) Funding Agency

_____ _____

___No **If "no,"** answer Question below:

5) If you had an available bed at your transitional housing facility, and a person who is not a member of that facility's target population requested a bed, would you deny the available bed to that person?

_____Yes **If "yes,"** answer Questions 5a. and 5b. below:

_____No **If "no,"** skip to Question 6.

5a. **If "yes,"** does the nature of the physical facilities reasonably necessitate a restriction of the facilities exclusively to your target population?

_____Yes **If "yes",** please explain (attach additional page if more space is required):

____ No

5b. Does the nature of the services provided at your transitional housing facility reasonably necessitate a restriction of the facilities exclusively to your target population?

_____Yes **If "yes",** please explain (attach additional page if more space is required):

_____No

If you answered "no" to both Questions 5a. and 5b. above, you are not eligible for EHAP funds. Ineligible applicants may contact EHAP staff for technical assistance.

6. Identify the maximum number of days (including extensions) a client will be sheltered by the facility/activity for which EHAP funding is requested: _____Days

7. Type(s) of client housing provided:

_____ Emergency Shelter (Answer only Questions 8-10, and then skip to Section C, "Narrative Questions")

_____ Transitional Housing w/Services (Skip Questions 8-10, answer Question 11 only, then complete Section C, "Narrative Questions")

8. Does the emergency shelter/facility reserve space for clients? _____ Yes _____ No
If yes, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is Yes.

9. Does the emergency shelter/facility require any fee, voucher or contribution from the client?
_____ Yes _____ No
If yes, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is Yes.

10. Are the rules of occupancy and maximum stay conspicuously posted at the emergency shelter?
_____ Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is No.

Emergency Shelter Applicants skip to Section C, "Narrative Questions"

Transitional Housing Applicants answer Questions 11 a.through g.;
then Complete Section C, "Narrative Questions"

11. For applicants providing transitional housing with services:

a. Are clients offered at least three self-sufficiency development services in conjunction with occupancy of the housing? (**List below the types of services provided**.)

_____Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is "No."

b. Is every client provided referrals or placements to permanent housing?

_____ Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is "No."

c. Does every client accumulate funds to be applied to renting permanent housing?

_____ Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is No. Note: Transitional housing applicants should mark this question "N/A", if rent is not charged.

d. Is rent charged for occupancy of the transitional housing? _____ Yes _____ No
If answer is "no," then type "N/A" for response to 11e, f, and g below.

e. Is rent equal to or less than 30% of each individual household's income?

_____Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is "No."

f. Is at least 10% of the rent set aside for the client to be used for rental of permanent housing?

_____Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is No.

g. Is the rent set aside accounted for separately for each client? _____ Yes _____ No

If no, shelter is not eligible. Contact State staff for guidance. Explain why your shelter should be considered eligible even though the answer to this question is No.

C. NARRATIVE QUESTIONS

Answer the following questions including all subparts and clarifying questions to describe your existing operations and demonstrate your capability to successfully complete the activities of your EHAP grant proposal.

Type each answer on no more than one page for each numbered question, and attach them at the end of Section I. More than one question per page is allowable.
Clearly identify the number of each response (e.g., 1a, 2b, etc. and c.q. for the clarifying questions).
Be sure to include all the information requested and attach additional supporting documentation as appropriate. The clarifying questions are important, so answer each one seperately as well.

1. Organization History.

   a. How long has the organization existed?
   b. How long has it been involved in providing client housing and services for the homeless?
   c. How many client beds does your emergency shelter/transitional housing facility provide?
   d. Demonstrate the applicant's record of stability and services to the community.

   Clarifying questions:
   - How long has the shelter proposed for funding been operated by this organization?
   - How long has the shelter been this size?
   - If your organization offers vouchers or residential rental assistance only, state this.

2. Organization Structure and Staffing.

   Describe:
   a. The organizational structure including board and staff;
   b. The numbers, duties, hours worked and experience of the paid and volunteer staff;
      --Use the Project Staffing grid provided to help you display this information easily.
      --A copy of the form can be found following the narrative questions.
   c. The level of community interest and involvement;
   d. If and how your facilities and/or services are coordinated with other organizations.

   Clarifying questions:
   - At 2(b), include information on how long key administrative, operations, and services staff have worked in their fields and for your organization.
   - What relevant educational and licensing qualifications do key staff have.
   - Be specific. Explain your plan for dealing with staff turnover, i.e. if a key staff person leaves, how will you maintain their function?

3. Client Assistance.

   Describe:
   a. The current shelter and/or transitional housing facilities and related services you provide;
   b. The types, and estimated numbers and percentages of primary/target clients served (e.g., single males, families, mentally disabled);
   c. Outreach to clients and homelessness prevention activities;
   d. Any specific services you provide for specific populations (e.g., substance abusers, domestic violence victims, AIDS patients);
   e. The impact and effectiveness of your facilities and/or services in meeting the local needs.

   Clarifying questions:

- Of the various possible target client groups, which does this program serve?
- Which ones does it specifically exclude?
- Provide any available quantifiable information on your success rate, however you define success.

4. Resource Development and Evaluation

Describe:
a. the organization's experience in using State or public funds;
b. private funding sources utilized;
c. fundraising activities;
d. existing financial management systems;
e. experience in monitoring achievement of goals for various programs.

Clarifying questions:

- Specifically describe your method of establishing the budget, approving payments, recording income and expenses, charging expenses to specific funding sources, preparing reports, and ensuring that expenses are consistent with the application.

5. By activity, the type(s) and amounts of client housing and/or related client services to be provided (e.g., the number of clients housed; the number of clients placed into jobs; and the milestones and timeframe for completion of each activity.)

If funded, you will be required to report on your progress in meeting these milestones (in the Semi-Annual Report (SAR). Be sure to clearly describe your objectives in a manner which allows for completion of these reports.

Clarifying questions:
- Describe services such as food, clothing, life skills education, medical screening, service referrals, specialized services such as mental health services, permanent housing statistics, follow-up counseling after move out, and employment/income support programs.

If EHAP funds are requested for any new element (i.e. new staff, new activity, new shelter), provide a timeline for implementing these new elements.

6. Clearly describe the needs the EHAP-funded facilities or activities will address in the community, and how these needs were assessed.

Clarifying questions:
- To the extent that the need for your program has been addressed by independently prepared reports, cite the reports and their data.
- If your project meets a need identified as a high priority in a county "continuum-of-care" plan, indicate this (make sure to indicate whether any other needs have a higher priority).

7. Provide a statement of how your proposed activities do not duplicate existing services.

Clarifying questions:

- Describe how your organization coordinates its services with other homeless service providers, to ensure that there is limited or no duplication of services.

8. Clearly describe the availability of other resources to support the proposed activities.

Clarifying questions:

- What has been the history of your funding sources? See example below.
- Are any of these sources no longer available?
- Do you expect that any funding sources will become unavailable?
- If you are proposing a new activity or an increased level of service, what other resources besides EHAP are necessary?
- What is the availability of these resources?

Example:

Funding Source	Year	Amount
List source here	list all years received	$
List next source	list all years received	$

9. Clearly describe why your organization specifically needs EHAP funds.

Clarifying questions:

- What would the specific consequences to your program be if the EHAP grant was not funded?
- General statements such as the shelter will have to close, or EHAP funds are needed to make up reductions in other funding sources will be scored lower than persuasive explanations of specific consequences.
- If the shelter itself is in jeopardy if EHAP funds are not provided, explain in detail why this is the case, what contingencies would first be explored, and what other reductions could be made in operations prior to a closure decision.
- Do not describe the number of homeless in your community, or the general need for homeless assistance in your community.

10. How do you plan to monitor and evaluate the progress and effectiveness of each EHAP-funded activity.

Clarifying questions:

- What staff is responsible for EHAP program compliance?
- What are the compliance duties of this staff?
- Are there uncleared monitoring findings from past EHAP contracts?

11. List all EHAP grants received directly or indirectly.

Note: For applications covering more than one Shelter Facility or Program, copy this page as many times as necessary and complete a separate sheet for each.

Applicant/Organization: _____ Project: _____ Address:_____

EHAP PROJECT STAFFING

Include all current and proposed project/program staff positions, (EHAP and non-EHAP-funded); include Volunteers as well.
Attach copies of duty statements for all positions listed below. Copy this page as necessary.

Position Title	Indicate if position is Key Staff (*)	Current Occupant (vacant or proposed)	Hours Worked Per Month	Years in This Position	Description and Number of Years of Other Related Experience

(*) Key staff consists of organization's executive directors and fiscal officers, and managers/supervisors, counselors and case managers that work directly with the program/shelter.

Applicant _____ Site/Project _____

D. INCOME AND EXPENSE STATEMENT: All applicants must complete columns B, C and D for your Homeless program.

(A) INCOME	(B) PRIOR FY ___/___ - ___/___	(C) CURRENT YEAR ___/___ - ___/___	(D) PROJECTED FY ___/___ - ___/___
Private Donations			
Local Govt._____			
State - EHAP			
State -Other _____			
FEMA			
CDBG			
Federal - Other _____			
Rental Income			
Fees			
Other_____			
Other_____			
TOTAL INCOME	$	$	$
EXPENSES			
Rent/Lease			
Debt service (principal & interest)			
Taxes			
Insurance			
Staff (for direct client services)			
Administration (incl. Admin. Staff)			
Maintenance			
Utilities			
Reserves			
Other_____			
Other_____			
TOTAL EXPENSES	$	$	$

Accountant Name _____ Phone Number _____

Auditor Name_____ Phone Number _____

**See next page for information regarding this form.

E. TYPE AND TOTAL AMOUNT OF EHAP GRANT REQUEST.
The total request must not exceed the limit stated in the NOFA.

Operating Facility Grant $_____

Operating Facility Grant with capital development-type activities of $20,000 or less $_____

Other contributions: (At the end of Section I, attach copies of commitment letters or other documentation of all firm funding commitments; label them question I.E.)

- To complete the grid below refer to the information provided on the Income and Expense Statement, Column D, page 16. Display in the grid below, the committed funds and anticipated funds from your projected fiscal years income.

FYI: The purpose of this grid is to break out the committed funds and the anticipated funds from your projected fiscal years income. Do not show your total project costs in the grid below, those costs are outlined on the Summary Budget and Fund Request, Column B, not within this grid.

Projected FY ___/___ - ___/___
(based on figures from Income and Expense Statement, Column D)

SOURCE	$ COMMITTED	$ ANTICIPATED
Federal		
State		
Local Government		
Private		
Total	$	$

**INCOME AND EXPENSE STATEMENT, Page 16

Column A: Displays your income sources and expenses.

Column B: Report your prior years funding information.

Column C: Report current funding information on your income and expenses for the fiscal year we are in right now.

Column D: The Income and Expense Statement on page 16 provides critical information to EHAP staff. Column (D), the Projected Fiscal Year (FY), should outline how your organization intends to spend funds in the next year. This should include the projection of EHAP funds for which you are applying via this application.

F. SUMMARY BUDGET AND FUND REQUEST - Operating Facility Grants:

Summarize the total project budget in the grid below; the project totals are taken directly from page 16, column D. Operating Facility grants may include $20,000 or less in capital development-type expenditures (lines 1 through 5), and the total EHAP grant request must not exceed $100,000 or the local allocation, whichever is less. Only 5% of the total grant amount can be used for administration. Be sure only eligible costs are charged to EHAP.

A	B	C	D	E
ACTIVITY	TOTAL Projected PROJECT COST (EXPENSES)	EHAP GRANT REQUEST	OTHER CONTRIBUTIONS	SOURCE OF CONTRIBUTION
1. Acquisition	$	$	$	
2. New construction				
3. Rehabilitation				
4. Conversion				
5. Equipment				
SUBTOTAL (lines 1-5)	$	$	$	
6. Administration				
7. Operations		*		
8. Mortgage Payments				
9. Lease/Rent				
10. Residential Rental Assistance				
11. Vouchers				
GRAND TOTAL (1-11)	$**	$***	$****	

* Total from Table G.

** Total from Income and Expense Statement, page 16, Column D, total expenses.

*** Amount from Income and Expense Statement, page 16, Column D, State – EHAP.

**** Show remaining contributions listed in Column D, projected fiscal year.

Applicant _____ Site/Project _____

G. DETAIL OF OPERATING FACILITY GRANTS

Detail of Operating Facility Grants	EHAP Grant Request	Job titles and percentage to be charged to EHAP grant
Staff providing services directly to clients (including payroll taxes)	$	
Counseling clients and supervising the counseling services (including payroll taxes)	$	
		*Show how this amount was calculated in the space provided below or attach an explanation and mark " See Attachment" in this space.
Utilities	$	
Office supplies, document duplication, printing, and mailing	$	
Routine maintenance and repairs	$	
Taxes and Insurance (for the housing site)	$	
Other (please specify) ** **(Do not** include Administration funds here.)	$	
TOTAL (must equal EHAP Grant Request for Operations (Table F, line 7.C.)	$	

*Note:
Provide a clear explanation of what the EHAP funds will pay for and show the calculations.

**Note:
Expenses involving food and transportation are NOT eligible under the EHAP regulations.
Please see EHAP Regulation 7962 for a listing of other ineligible activities.

STATE OF CALIFORNIA

PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD. 204 (REV. 2-2000)

NOTE: Governmental entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1 PLEASE RETURN TO:

DEPARTMENT/OFFICE

STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE NUMBER

PURPOSE: Information contained in this form will be used by state agencies to prepare information Returns (Form 1099) and for withholding on payments to nonresident payees. Prompt return of this fully completed form will prevent delays when processing payments.

(See Privacy Statement on reverse)

2 PAYEE'S BUSINESS NAME

MAILING ADDRESS *(Number and Street or P. O. Box Number)*

(City, State and Zip Code)

3 VENDOR ENTITY INFORMATION

CHECK ONE BOX ONLY

- ☐ **LEGAL CORPORATION**
- ☐ **PARTNERSHIP**
- ☐ **MEDICAL CORPORATION**
- ☐ **ESTATE OR TRUST**
- ☐ **EXEMPT CORPORATION**
- ☐ **ALL OTHER CORPORATIONS**

FEDERAL EMPLOYERS IDENTIFICATION NUMBER (FEIN)

- ☐ **INDIVIDUALOR SOLE PROPRIETOR**

SOCIAL SECURITY NUMBER OF OWNER

OWNER'S FULL NAME *(Print)*

NOTE: State and local governmental entities, including school districts are not required to submit this form.

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4 PAYEE RESIDENCY STATUS

CHECK APPROPRIATE BOX(ES)

- ☐ California Resident - Qualified to do business in CA or a permanent place of business in CA
- ☐ Nonresident *(See Reverse)* Payments to nonresidents for services may be subject to state withholding
  - ☐ WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED
  - ☐ SERVICES PERFORMED OUTSIDE OF CALIFORNIA/ GOODS ONLY SOLD TO CALIFORNIA

NOTE:
a. An estate is a resident if decedent was a California resident at time of death.
b. A trust is a resident if at least one trustee is a California resident.
(See reverse)

5 CERTIFYING SIGNATURE

I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME *(Type or Print)*

TITLE

SIGNATURE

DATE

TELEPHONE NUMBER

STATE OF CALIFORNIA
PAYEE DATA RECORD
STD. 204 (REV. 2-2000) (REVERSE)

ARE YOU A RESIDENT OR A NONRESIDENT?

Each corporation, individual/sole proprietor, partnership, estate or trust doing business with the State of California must indicate their residency status along with their taxpayer identification number.

A **corporation** will be considered a "resident" if it has a permanent place of business in California. The corporation has a permanent place of business in California if it is organized and existing under the laws of this state or, if a foreign corporation has qualified to transact intrastate business. A corporation that has not qualified to transact intrastate business (e.g., a corporation engaged exclusively in interstate commerce) will be considered as having a permanent place of business in this state only if it maintains a permanent office in this state that is permanently staffed by its employees.

For **individuals/sole proprietors**, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose which will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident.

For withholding purposes, a **partnership** is considered a resident partnership if it has a permanent place of business in California. An estate is considered a California estate if the decedent was a California resident at the time of death and a trust is considered a California trust if at least one trustee is a California resident.

More information on residency status can be obtained by calling the Franchise Tax Board at the numbers listed below:

From within the United States, call.....1-800-852-5711
From outside the United States, call.....1-916-845-6500
For hearing impaired with TDD, call....1-800-822-6268

ARE YOU SUBJECT TO NONRESIDENT WITHHOLDING?

Payments made to nonresident payees, including corporations, individuals, partnerships, estates and trusts, are subject to withholding. Nonresident payees performing services in California or receiving rent, lease or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for state income taxes. However, no withholding is required if total payments to the payee are $1500 or less for the calendar year.

A nonresident payee may request that income taxes be withheld at a lower rate or waived by sending a completed form FTB 588 to the address below. A waiver will generally be granted when a payee has a history of filing California returns and making timely estimated payments. If the payee activity is carried on outside of California or partially outside of California, a waiver or reduced withholding rate may be granted. For more information, contact:

Franchise Tax Board
Nonresident Withholding Section
Attention: State Agency Withholding Coordinator
P.O. Box 651 Sacramento, CA 95812-0651
Telephone: (916) 845-4900
FAX: (916) 845-4831

If a reduced rate of withholding or waiver has been authorized by the Franchise Tax Board, attach a copy to this form.

PRIVACY STATEMENT

Section 7(b) of the Privacy Act of 1974 (Public Law 93-5791) requires that any federal, state, or local governmental agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State must provide their Taxpayer Identification Number (TIN) as required by the State Revenue and Taxation Code, Section 18646 to facilitate tax compliance enforcement activities and to facilitate the preparation of Form 1099 and other information returns as required by the Internal Revenue Code, Section 6109(a). The TIN for individual and sole proprietorships is the Social Security Number (SSN).

It is mandatory to furnish the information requested. Federal law requires that payments for which the requested information is not provided be subject to a 31% withholding and state law imposes noncompliance penalties of up to $20,000.

You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the state agency(ies) with which you transact that business.

Please call the Department of Finance, Fiscal Systems and Consulting Unit at (916) 324-0385 if you have any questions regarding this Privacy Statement. Questions related to residency or withholding should be referred to the telephone numbers listed above. All other questions should be referred to the requesting agency listed in Section 1.

Applicant _____ Site/Project_____

SECTION III: ADDITIONAL GRANT PROPOSAL INFORMATION FOR OPERATING FACILITIES WITH CAPITAL DEVELOPMENT-TYPE ACTIVITIES (i.e. Acquisition, New Construction, Rehabilitation, Conversion, or Equipment)

A. SITE DESCRIPTION: Copy this page as needed if project involves scattered sites to prepare a separate summary for each site. Attach additional pages as needed to answer the questions.

1. Is the site currently owned or leased (circle one) by applicant? ____ Yes ____ No
   If yes, since when? ____/____/____If lease, give term:____/____/____ to ____/____/____
   If not owned, give name and address of current legal owner and describe how title is held:

2. If site acquisition is proposed, briefly describe the timeframe, financing, and any unusual issues:

3. Legal property description:

4. Land use description:

   Current Zoning Designation: _____

   Current General Plan Designation: _____

   Do current zoning and general plan designations permit use for

   emergency shelter or transitional housing? _____ Yes _____ No

   If no, how will the proposed facility be accommodated, and when? ____/____/____

   [ ] Rezoning [ ] General Plan amendment
   [ ] Zoning Variance [ ] Conditional Use Permit
   [ ] Other_____

5. Has the certificate of occupancy been issued? _____ Yes _____ No

   If yes, give date ____/____/____, and ____ number of persons.

6. Lot Size: _____ Sq. Ft. or _____ acres

Applicant _____ Site/Project _____

7. Building Information: ____ Existing ____ Proposed (check one, and briefly describe number, type, and square footage of the buildings)

Total Number of:

Rooms	_____	Bedrooms	_____
Beds/Spaces	_____	Kitchen(s)	_____
Bathroom(s)	_____	Office	_____
Dining	_____	Recreation/Living	_____

Other: _____

B. PROJECT ACTIVITIES SCHEDULE:

Show the schedule of the steps required to complete the capital development activities including the expected dates when each step will be accomplished. Include such steps, as applicable, as preparing the plot map, obtaining local planning and building department approvals, preparing bid packages, executing construction contracts, starting and completing construction, and closing escrow.

Applicant _____ Site_____

C. DETAILED COST ESTIMATES FOR OPERATING FACILITIES WITH CAPITAL DEVELOPMENT ACTIVITIES: Copy additional pages, as needed.

Estimator's Name: _____ Profession: _____

Estimator's Signature: _____ License: _____

Summarize the work or equipment items by activity (e.g., rehabilitation, conversion). Figures here should be carried forward to the Summary Budget and Fund Request. Note that after the grant award, competitive bidding is required to determine building contractor(s) and/or major equipment supplier(s).

A	B
Work or Equipment Item - Include quantity and unit cost, or hours and hour cost	Total Cost

SAMPLE RESOLUTION INSTRUCTIONS/CHECKLIST

The Resolution accompanying an application for the Emergency Housing and Assistance Program (EHAP) must include the information contained in the Sample Resolution. Please confirm the following requirements have been met:

- The Sample Resolution language and format (see Sample Resolution next page) has been used and retyped on your organization's letterhead (**Do not use the Sample Resolution page**).

- The name of the applicant organization that is listed on the Resolution must match the organization name that appears on the Articles of Incorporation filed with the Secretary of State. Be consistent throughout the Resolution to use the exact name. **Do not include DBAs or names of project sites or programs.**

- The Resolution shows the date of the board action to approve the Resolution. For organizations in Non-Designated Local Board (DLB) counties this board action must occur after September 12, 2003 and on or before November 13, 2003. For organizations in DLB counties the resolution must be executed after the date the NOFA was issued and before the application deadline.

- The title/office of the person authorized to sign the Standard Agreement (and not the specific person's name) was included.

- The vote tally section has been fully completed, including noting the number of Ayes, Noes, Abstentions and Absentees.

- The Approving Officer, who signs the Resolution, cannot be the Authorized Officer named to sign the EHAP Application and the EHAP Standard Agreement.

- The "Approving Officer" and the "Attest" lines have been signed and the required titles/names have been printed below the signatures.

Please make sure the Resolution has been prepared using the Sample Resolution format. In past years, approximately 25% of the Resolutions contained errors or omissions. Following up with grantees to obtain corrected Resolutions is extremely time consuming and causes delays in executing Standard Agreements.

If you have any questions regarding the required Resolution, please call the EHAP staff at (916) 445-0845 or e-mail bstolk@hcd.ca.gov. If you would like the Sample Resolution sent to you by e-mail or on disk, please contact Barbara Stolk at the above phone number or e-mail address.

SAMPLE RESOLUTION

RESOLUTION

WHEREAS:

A. The State of California, Department of Housing and Community Development, Division of Community Affairs, issued a Notice of Funding Availability (NOFA) for the Emergency Housing and Assistance Program (EHAP) (Round #EHAP-XI); and

B. [_____] is a nonprofit corporation or local
(Insert Name of Application Organization)
government agency that is eligible and wishes to apply for and receive an EHAP grant;

NOW THEREFORE BE IT RESOLVED THAT:

1. The Board of Directors of [_____] hereby authorizes
(Insert Name of Applicant Organization)
[_____] to apply for an EHAP grant in an amount not more than the
(Insert Title of Authorized Person/Officer)
maximum amount permitted by the NOFA, and in accordance with the program statute, Regulations, and Local Emergency Shelter Strategy, where applicable.

2. If the grant application authorized by this Resolution is approved, the [_____]
(Insert Name of Applicant Organization)
hereby agrees to use the EHAP funds for eligible activities in the manner presented in the application as approved by the Department and in accordance with the program statute (Health and Safety Code Section 50800 – 50806.5) and Regulations (Title 25, Division 1, Chapter 7, Subchapter 12, Sections 7950 through 7976 of the California Code of Regulations); (Chapter 157, Statutes of 2003), and the Standard Agreement.

3. If the grant application authorized by this Resolution is approved, [_____]
(Insert Title of Authorized Person/Officer)
is authorized to sign the Standard Agreement and any subsequent amendments with the Department for the purposes of this grant. *(*Remember to use only the **title** of the person in case of staff/board turnover. Delays caused by naming individuals may jeopardize your grant.)

PASSED AND ADOPTED at a regular meeting of the [_____]
(Insert Name of Applicant Organization)
this ____ day of _____, 200__ by the following vote:

AYES: _____ ABSTENTIONS: _____

NOES: _____ ABSENT: _____

_____
Signature of Approving Officer

_____
Printed Name and **Title** of Approving Officer

ATTEST:_____
Signature and **Title**

APPENDIX A

SERVING SELECTED POPULATIONS WITH EHAP FUNDING

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT
DIVISION OF COMMUNITY AFFAIRS
1800 Third Street, Suite 390
P. O. Box 952054
Sacramento, CA 94252-2054
(916) 322-1560
FAX (916) 327-6660

Serving Selected Populations With EHAP Funding

September 12, 2002

The following is a simplified layman's guide for shelter providers seeking to serve selected populations using Emergency Housing and Assistance Program (EHAP) funds administered by this department.

Legal Requirements:

Generally, service to selected populations must comply with a variety of legal requirements, including the 14th Amendment to the U. S. Constitution, the U. S. Fair Housing Act (and amendments) of 1968 (and 1988), the California Fair Employment and Housing Act and the California Unruh Civil Rights Act. Depending on the circumstances, other statutes may apply, including Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Additionally, there are specific applicable provisions of the EHAP Statutes (Health and Safety Code Section 50800, et seq.) Given the potential overlap of legal requirements, shelter providers should consult an attorney to identify the specific applicable requirements for serving any selected population of clients.

EHAP Emergency Shelter "First-Come, First-Served" Requirements:

Emergency shelter facilities receiving funds from EHAP are required (See H&S Section 50801.5(b).) to provide emergency shelter and services *"...on a first-come, first served basis for whatever time periods are established for the shelter."* HCD believes that this provision prohibits the use of EHAP funds for emergency shelters for selected populations. However, recognizing that many shelter providers have mission-driven restrictions, HCD has allowed the funding of such shelters provided that no homeless individual or family is forced to remain without shelter while there is available bed space. In circumstances where any client is denied shelter when there is a vacancy, EHAP emergency shelter providers must ensure that there is adequate alternate accommodation - including arranging for a bed or providing a voucher for a bed at an alternate facility and reasonable transportation to that facility.

EHAP Transitional Housing:

Transitional housing facilities receiving funds from EHAP are not subject to the first come, first-served provisions like emergency shelter facilities, but they are still subject to other legal requirements affecting client service. Among those requirements are EHAP regulations (Section 7959 (e)), which, as an eligibility requirement, prohibit EHAP applicants or grantees from providing client housing in a manner that denies benefits on an arbitrary basis, and case law for the Unruh Civil Rights Act, which prohibits all arbitrary discrimination. Under Unruh,

discrimination is considered non-arbitrary if the nature of the physical facilities or the nature of the services provided reasonably necessitates a particular restriction. Because whether a transitional housing provider is in compliance with Unruh is a fact driven question, applicants and contractors are encouraged to consult their own legal counsel regarding this issue.

If a State or Federal law or regulation requires an EHAP transitional housing facility to exclusively serve a select homeless subpopulation, such a restriction would not be considered arbitrary.

Stewart B. McKinney Homeless Assistance Act (McKinney Act) Compatibility:

H&S Section 50800 (c) allows EHAP funds to be used in emergency shelter facilities receiving funds from McKinney Act Programs which require exclusive services to selected populations – provided that the McKinney Act client restrictions arise in the McKinney Program law or regulations (as opposed to restrictions arising from those self-imposed by the applicant/shelter provider.) Contracts between the shelter provider and HUD that merely codify client restrictions proposed by McKinney Act recipients are insufficient basis for invoking the McKinney Act exemption to the EHAP first-come, first-served requirements.

Selecting Clients on the Basis of Sex:

H&S Section 50801.5 (b) effectively allows emergency shelter and transitional housing providers using EHAP funds to restrict occupancy on the basis of sex – provided that the restrictions are not arbitrary. Generally, that means that in EHAP funded facilities, notwithstanding the Unruh Civil Rights Act~~s~~ or any other provision of law, shelter and services may be offered exclusively for either women or men – provided that any such exclusivity is based on a reasonable service need.

Selecting Clients on the Basis of Age:

H&S Section 50801.5 (b) also permits emergency shelter and transitional housing providers to restrict occupancy exclusively to persons 24 years of age or younger. Generally, that means that in EHAP-funded facilities, notwithstanding the Unruh Civil Rights Act or any other provision of law, shelter and services may be offered exclusively to persons 24 years of age or younger – provided that any such exclusivity is based on a reasonable service need.

Selecting Clients on the Basis of Family Status:

With respect to using EHAP funds for shelter and services exclusively for either women or men (as allowed under H&S Section 50801.5(b) indicated above) there are limits to the restrictions that can be imposed when serving families. In the case of families, providers of emergency shelter or transitional housing which operate single sex facilities shall provide, to the greatest extent feasible, adequate facilities within their range of services so that all members of a family may be housed together, regardless of age and gender. In other words, families should not be forced to split up in order to stay in EHAP funded facilities that would otherwise exclusively serve either men or women.

If there are any questions regarding these issues, please contact the HCD Homeless Programs at (916) 445-0845.